45 E. Milwaukee Street | Detroit, Michigan 48202
t: (313) 972-1400 | f: (313) 972-4662 | dencap.com

dencap DENTAL PLANS

DENCAP Dental Plans Enrollment Form: Individual Value Dental (IN)

Clear Data

LAST NAME (Print)	FIRST	INITIAL	DATE OF BIRTH MONTH DAY YEAR	SEX	SOCIAL SECURITY NUMBER
STREET ADDRESS		Apt#		☐ M ☐ F	– –
CITY	STATE	ZIP	PHONE NUMBER:		
Dental Office Selection *(Choose ONE using a 3 digit number from Provider Directory)* ☐☐☐ *Go to dencap.com for an office locator.*			E-MAIL:		

LIST ALL DEPENDENTS TO BE COVERED BELOW. ☐ *Additional dependents provided separately.*		DATE OF BIRTH MONTH DAY YEAR	SEX	SOCIAL SECURITY NUMBER
SPOUSE			☐ M ☐ F	– –
DEPENDENT			☐ M ☐ F	– –
DEPENDENT			☐ M ☐ F	– –

How did you hear about DENCAP? ☐ Web Search ☐ Billboard ☐ Agent: _____ ☐ Other: _____

Please begin my coverage on the FIRST DAY of: Month _____ Year _____ **I wish to enroll in:** ☐ Dental Only OR ☐ Dental and Vision

☐ **Annual** Payment by **Check or Money Order.** *(Sign below)*
Be sure to enclose check or money order payable to DENCAP for the full ANNUAL Premium.

☐ **Annual** Payment by **Credit/Debit Card.** *(Sign below)* ***Charge Date: To be charged ASAP***

Card Holder/Name on Card: _____

Billing Address: _____ City: _____ State: _____ Zip: _____
The street address and zip code are both required to process payment.

Credit/ Debit Card #: _____ Credit/Debit Expiration Date: _____ CVV Code: _____

☐ Visa ☐ MC ☐ Disc ☐ Amex

Annual Rates

Dental Only:
Single: $324.00
2 Persons: $564.00
Family: $804.00

Dental and Vision:
Single: $468.00
2 Persons: $804.00
Family: $1,236.00

☐ **12 Monthly Installments** by **Credit/Debit Card.** ***Billing Withdrawal Date is the 25th of each month***
(After which, plan automatically renews on a monthly basis. Sign below.)

Card Holder/Name on Card: _____

Billing Address: _____ City: _____ State: _____ Zip: _____
The street address and zip code are both required to process payment.

Credit/ Debit Card #: _____ Credit/Debit Expiration Date: _____ CVV Code: _____

☐ Visa ☐ MC ☐ Disc ☐ Amex

☐ **12 Monthly Installments** by **ACH (Bank Draft).** ***Billing Withdrawal Date is the 25th of each month***
(After which, plan automatically renews on a monthly basis. Sign below.) ***Enclose voided check or bank letter with account and routing numbers.***

Monthly Rates

Dental Only:
Single: $29.00
2 Persons: $49.00
Family: $69.00

Dental and Vision:
Single: $41.00
2 Persons: $69.00
Family: $105.00

PLEASE READ TERMS BEFORE SIGNING BELOW

I authorize payment on my credit/debit card (if applicable) or bank draft (if applicable) by signing below. I understand that the first charge to activate coverage will take place upon receipt of this enrollment. In some cases due to the effective date selected, the first payment may be for 2 months' coverage _____ (initial), or the selected coverage effective date will be moved forward. I understand that all future premiums will be charged to my credit/debit card (if applicable) or bank draft (if applicable) one month in advance. Monthly Premiums collected are non-refundable.

I understand that I am responsible for the co-payments on all services received as specified in the Schedule of Benefits & Co-payments and for full payment of all other non-covered dental services. I am responsible for notifying DENCAP in writing of changes in coverage or payment information 7 days prior to my scheduled payment. Failure to do so may result in fees, and/or the cancellation of my policy. By signing below I agree to these terms.

Fraud Warning: Any person who, knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Account Holder Signature: _____ **Date:** _____

• If submitting electronically, type your name in the account holder signature box.
(Your e-mail to DENCAP serves as a binding signature.)

Email This Form

f5: V.07.13.21

Return this form to: DENCAP Dental Plans, Inc., 45 E. Milwaukee St., Detroit, MI 48202. Or fax to 313-972-4662. Or email to info@dencap.com

Internal Information to be filled out by DENCAP Dental Plans

Confirmed enrollment with: _____ Date: _____ Time: _____ Agent: _____ General Agent: _____